## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

**************************************		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395771	IFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:  A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 03/17/2023	
NAME OF PROVIDER OR SUPPLIER:  LAKESIDE AT WILLOW VALLEY  STATE LICENSE NUMBER: 233602			STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WILLOW VALLEY LAKES DRIVE WILLOW STREET, PA 17584					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE	
F 0000	Based on a Medicare Recertification, State Licensure and Civil Rights Compliance Survey completed on March 17, 2023, at Lakeside at Willow Valley, it was determined that no deficiencies were identified under the requirements of 42 CFR Part 483, Subpart B, Requirements for Nursing Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations for the Health portion of the survey process.		F 0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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## **Certified End Page**

## LAKESIDE AT WILLOW VALLEY

STATE LICENSE NUMBER: 233602 SURVEY EXIT DATE: 03/17/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

## **PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY